Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS DOCTOR'S PROFESSIONAL ASSOC
PO BOX 781667
DALLAS TX 75378

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN GUARANTEE & LIABILITY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-9557-01

MFDR Date Received
June 22, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's position summary dated June 17, 2009: "Payment should have originally been made by Zurich at the reasonable 125% of Medicare rates according to Dallas County, Tx…"

Requestor's supplemental position summary dated July 10, 2009: "Our facility felt it was necessary to bring to your attention some ADDITIONAL pertinent information that was not originally included in our facility's MDR letter. Regarding the PPO agreement the Carrier (Zurich) is basing their payment reimbursement on, it would be invalid for the above dates of service, as the services were performed and billed under a D.O. PPO would pertain to Chiropractic services, which IS NOT the case with the treatment provided by our facility. As well, MedRisk does not process services performed by an M.D./D.O. Our facility has been directed to directly submit the bills to the insurance carrier for payment if having been billed under a M.D./D.O. Our facility received correspondence via fax on 07-09-09, which included EOR's from Zurich that showed their original reductions for the above dates of service. As indicated in our prior documentation, those amounts were not the amounts received by our facility and as stated before, our facility had no contractual agreement with Zurich for MedRisk to process the claims for payment/make the payments to our facility under any capitation, etc. The payments received were from MedRisk. …Our facility is simply stating that the manner in which the bills were handled/processed and reimbursed (capitated) through MedRisk was incorrect and we are seeking the properly reduced remainder of the balance of payments we should have been reimbursed by the Carrier."

Amount in Dispute: $2,224.03 per Table of Disputed Services

RESPONDENT'S POSITION SUMMARY

Respondent's original response dated July 10, 2009 states in part, "Provider submitted a request for medical dispute resolution on June 22, 2009 for healthcare services provided from October 10 through November 10, 2008 and is seeking reimbursement for some unknown total. Carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Respondent's supplemental response dated April 8, 2010 states in part, "Carrier has previously responded to this dispute. Please note that carrier has escalated the disputed billing for re-audit and payment as appropriate."

Respondent's supplemental response dated October 28, 2010 states in part, "Carrier has previously responded to this dispute on July 10, 2009. Carrier maintains its position as outlined in the original response and will supplement its response with a copy of the contract in question shortly.

Response Submitted by: Flahive, Ogden & Latson; Post Office Drawer 13367; Austin Texas 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 17, 22, 23, 24, 27, 29, 31, 2008 November 3, 5, 7, 10, 2008	97530-59-GP x 2 units x 12 days	$2,202.33	$2,202.33
October 10, 17, 22, 23, 24, 27, 29, 31, 2008 November 3, 5, 7, 10, 2008	97110-GP x 3 units x 12 days		
October 10, 17, 22, 23, 24, 27, 29, 31, 2008 November 3, 5, 7, 10, 2008	97140-GP, 97018-59-GP, 97022-GP x 12 days		
October 10, 17, 27, 29, November 3, 5, 10, 2008	97032-GP x 7 days		
		TOTAL DUE	$2,202.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

The requestor's Table of Disputed Services listed two duplicate entries for date of service October 29, 2008.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason code(s) per MedRisk explanation of benefits:
   - 45: charge exceeds your contracted/legislated fee arrangement.
   - 509-001: Correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day as code
   - 663: Reimbursement has been calculated according to the state fee schedule guidelines.

Issues

1. Did the respondent support its PPO reductions?
2. Is the requestor entitled to additional reimbursement according to 28 Texas Administrative Code §134.203?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement based upon "45 - charge exceeds your contracted/legislated fee arrangement".

   Former Texas Labor Code §413.011(d-1) states, in pertinent part, that "…an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the Division if the insurance carrier…has a contract with the health care provider and that contract includes a specific fee schedule…"

   On March 22, 2010 and again on October 14, 2010 the Division requested additional information. Specifically, medical fee dispute resolution requested a copy of the contract between the informal/voluntary network and Dallas Doctor's Professional Association; and documentation to support that the requestor was notified in accordance with commissioner rule 28 Texas Administrative Code §133.4 titled *Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks*.

   The respondent failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed according to Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (b) states "for coding, billing, reporting, and reimbursement of

professional medical services, Texas workers' compensation system participants shall apply the following (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203 (c) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. 28 Texas Administrative Code §134.203 (h) states "When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the (1) MAR amount.

The MAR is calculated as follows:

- CPT code 97530: Workers' Compensation (WC) conversion factor (CF) $52.83 ÷ Medicare CF $38.087 x participating amount $29.17 = $40.46 x 2 units = $80.92 x 12 days = $971.04.

- CPT code 97110: WC CF $52.83 ÷ Medicare CF $38.087 x participating amount $27.60 = $38.28 x 3 units = $114.85 x 12 days = $1378.20.

- CPT code 97140: WC CF $52.83 ÷ Medicare CF $38.087 x participating amount $25.64 = $35.56 x 12 days = $426.72.

- CPT code 97032: WC CF $52.83 ÷ Medicare CF $38.087 x participating amount $15.95 = $22.12 x 7 days = $154.84.
  (There is no dispute for CPT code 97032 billed on October 22, 23, 24, 31; and November 7, 2008)

- CPT code 97018: WC CF $52.83 ÷ Medicare CF $38.087 x participating amount $7.45 = $10.33 x 12 days = $123.96.

- The respondent denied reimbursement for CPT code 97022 based upon "509-001: Correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day as code".

  Per national correct coding initiatives, "CPT code 97022 (whirlpool therapy) is a component procedure to CPT code 97018 (paraffin bath therapy). The Standard Policy Statement reads 'mutually exclusive procedures'. The use of an appropriate modifier may be allowed." CPT code 97022 was billed with an appropriate modifier on November 10, 2008 only.
  CPT code 97022: WC CF $52.83 ÷ Medicare CF $38.087 x participating amount $16.80 = $23.30

- The total maximum allowable reimbursement (MAR) for the eligible disputed services is $3,078.06.
- The respondent paid $850.00 per the Table of Disputed Services.
- The requestor is seeking $2,202.33 per the Table of Disputed Services, this amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the eligible disputed services in this dispute. As a result, the amount ordered is $2,202.33**.**

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,202.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.